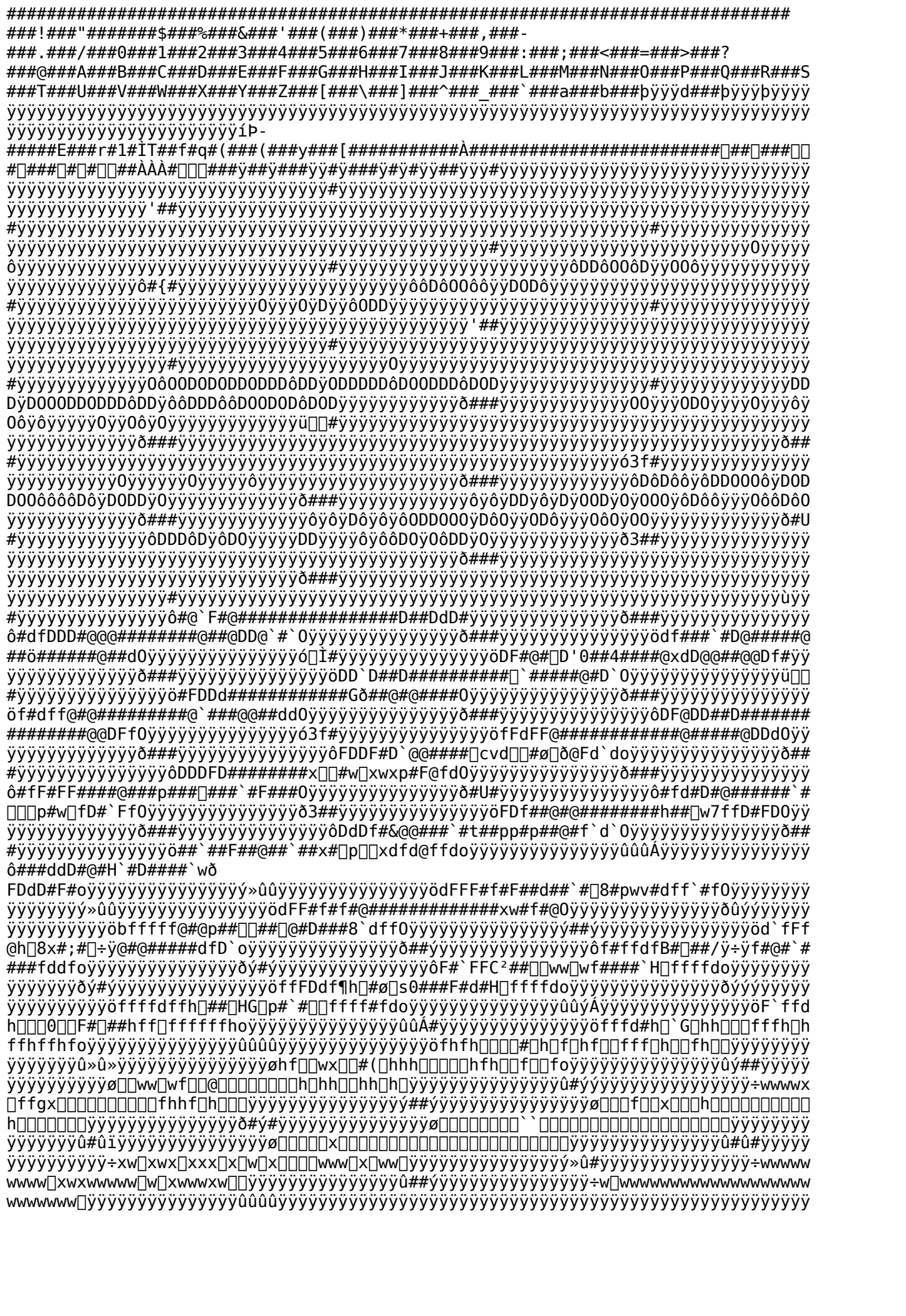

```
#################,##########################ÿ□#ÿÿd#########d#########2##□##ªö□üV
      s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########y###MalesSmokersOverweightMiddle-
aged: shipyard workersYounger: think cocaine useRecent increase in exertion
(e.g.. PRT)#
```

#################,##########################ÿ□#ÿÿd#########d#########2##□##êõýûv
ã### #########T#ä###K#########d#########□###Family hx (1st degree relative < 55 yrs)Smoking *HTN *Cholesterol *DMMale genderDocument CRFs in Every CP Patient!
(* modifiable risks)

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#"#########"#####,###########"#########"####ÿ□#ÿÿd#########d#########2##□##ªö□üV
      s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########¿###SubsternalVisceral - vague
burning, squeezing, tightness, heavinessRadiates to neck, jaw, L shoulder/arm
Upper abdominal pain - think IMIAtypical pain - coronary spasm, female, elderly,
DM#
```

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0############ýÿ##Ü#g/####õ#ð÷ð
      çú############ýÿ##########Î############2##□##□#□üF
##ÿÿ####ÿÿ####Uÿä#ÿÿK#########d#########T###Reproduced by bending or palpation
Relieved by exertionPrompt relief with NTG or O2

#################,###########################ÿ□#ÿÿd#########d#########2##□##ªö□üV
s#ÿÿ####ÿÿ####Uÿu#ÿÿK#########d#########·###Base treatment on hx and
clinical setting - NOT EKG findings!initial EKG may be normal in AMI>1 mm ST
elevation in 2 leads - acute transmural MIonly seen in 40-50% at presentation#

#################,##########################ÿ□#ÿÿd#########d#########2##□##ºõ□üf
#s#ÿÿ####ÿÿ####Uÿu#ÿÿK#########d#########ª###Most AMIs have nonspecific EKG
abnormalities:T wave inversionST depressionabout 1/3 will develop non-Q wave MI
3/4 of non-Q wave MIs present with ST-segment depression

#################,###########################ÿ□#ÿÿd#########d#########2##□##ªö□üV
s#ÿÿ$###ÿÿ####Uÿä#ÿÿK##########d#########l###Primary value is to R/O pneumonia, PTX, wide mediastinumMay see cardiomegaly (with IHD, HTN, old MI) or CHF

```
#################,##########################ÿ□#ÿÿd#########d#########2##□##ªö-üV
      ##ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########Ò###Gold standard: CK-MBrise
within 4-6 hrspeak in 10-36 hrsreturn to normal in 48-72 hrsRepeat CK-MB q4-6
hrs x 18-24 hrsDx of MI usually made in 8-12 hrsSingle CK-MB 80-99% specific but
only 30-40% specific
```

#################,##########################ÿ□#ÿÿd#########d#########2##□##ªö□üF
#s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########n###LDH, SGOT: limited valueMyoglobin,
Troponin I and T: early markers (higher sensitivity) but lower specificity

#*#########*#####,###########*#########*####ÿ□#ÿÿd#########d#########2##□##ªö□üV
s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########[###2-D echocardiography
Radionuclide cardiac scanningCan□t distinguish new from old infarctsi

```
#################,##########################ÿ□#ÿÿd#########d#########2##□##ªö□üV
      s#ÿÿ(###ÿÿ####Uÿä#ÿÿK#########d#########º###NTG  SL - 0.3-0.4 mg q5 min x
3NTG IV - start at 10-20 mcg/min, titrate 5-10 mcg/min q 5-10 minMSO4 2-4 mg IV
q 5-30 minSafe w/o hemodynamic monitoringBeware hypotension, bradycardia
```

#$#########$#####,###########$#########$####ÿ□#ÿÿd#########d#########2##□###öíüÆ
#Ó#ÿÿ####ÿÿ####Uÿu#ÿÿK#########d#########ª###Aspirin 325 mg POGIVE TO ALL PTS UNLESS CONTRAINDICATED!reduces MI mortality, strokeHeparin IVadjunct to thrombolysismay prevent reocclusionunstable angina, nonQ MI

```
#################,##########################ÿ□#ÿÿd#########d#########2##□##ªö□üF
s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########□###PROMPT ADMINISTRATION IS MORE
IMPORTANT THAN CHOICE OF AGENTADJUNCTIVE RX FURTHER REDUCES MORTALITY SEEN WITH
THROMBOLYTICS ALONE#
```

#$#########$#####,###########$#########$####ÿ□#ÿÿd#########d#########2##□##*û]üf
#C#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########□###Chest pain >30 min and <12 hrs
durationST elevation >1 mm in two contiguous limb leadsST elevation >2 mm in two
contiguous chest leadsnew BBB

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      æ###□#####æ#####2##□##j#□üV
      s#ÿÿ####ÿÿ####Tÿä#ÿÿK#########d#########□###major trauma or surgery w/in 2
wksrecent head injurypregnancyanticoagulationbleeding disordertraumatic CPRdrug
allergy                       (age)
```

#)#########)#####,###########)#########)####ÿ□#ÿÿd#########d#########2##□##ªö□ü□
ÿs#ÿÿ ###ÿÿ####Uÿä#ÿÿK#########d#########□###altered LOCaortic dissectionCNS mass or bleedactive GI bleedingspinal or cranial surgery w/in 2 mos.SBP>200 mmHg, DBP>120 mmHg:

#################,##########################ÿ□#ÿÿd#########d#########2##□##
ú□üÆ#s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########T###30 units IV bolus over 3 min4-6
hrs later: heparin 5000-7500 U IV, then 1000 U/hr

#)#########)#####,###########)#########)####ÿ□#ÿÿd#########d#########2##□##Úö-üæ
##ÿÿ####ÿÿ####Tÿä#ÿÿK#########d#########Ù###MI R/O□d in 35 of 609 pts given thrombolytic agentsIn-hospital complications similar to MI group2/35 deaths (aortic dissection, pericarditis)No major hemorrhagesSource: Khoury et al, Ann Emerg Med 28:289-293, 1996#

```
###############,########################ÿ□#ÿÿd#########d#########2##□###ö□üF
s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########í###Reduce MVO2; antiarrhythmic effects
Decrease MI mortality 13% by day 7Atenolol 5 mg IV x 2 over 20 min, then 50 mg
PO 15 min laterMetoprolol 5 mg IV x 2-3 over 15-30 min, then 100 mg PO 15 min
laterBeware: CHF,  COPD, AV block, hypoBPÿ
```

```
#     #########   #####,########### #########
      ####ÿ□#ÿÿd#########d#########2##□##ªö□üV
      s#ÿÿ####ÿÿ####Tÿä#ÿÿK#########d#############Calcium mediator,
antiarrhythmicReduces mortality 35-50% at 1-4 wksMost effective before
thrombolysis?MgSO4 2 gm IV over 5 min, then infusion over 24 hrsBeware
hypotension, complete heart block, renal failureSource: Antman, Am Heart J
132:487-94, 1996 #
```

#################,##########################ÿ□#ÿÿd#########d#########2##□##ªö□üV
      s#ÿÿ$###ÿÿ####Uÿä#ÿÿK#########d#########É###Probably better than thrombolysisMechanical opening of vesselBetter long-term resultsIndicated immediately when thrombolysis contraindicated or failsNot available at many centers (including ships!)#

#################,##########################ÿ□#ÿÿd#########d#########2##□##ºõ□ü#
s#ÿÿ####ÿÿ####Tÿä#ÿÿK#########d#########H###USAF regs: no routine evac for 10 days after AMI; no complications for 5 days7 pts flown by USAF 2-7 days after AMI: no complications or deaths w/in 24 hrsSource: Connor & Lyons, Mil Med 160:491-493, 199590 pts on intl commercial aircraft 3-14 days after AMI: 6 problems, 1 late deathSource: Cox et al., ASEM 67:976-82, 1996

#################,##########################ÿ#ÿÿd#########d#########2####êõ]ü#
#C#ÿÿ ###ÿÿ####Uÿä#ÿÿK#########d#########°###Maintain high index of suspicion
Document risk factors in every CP patientMentally rule out 5 life-threatening
causes in every CP patientStabilize with IV/O2/monitor/pulse ox

#################,#########################ÿ□#ÿÿd#########d#########2##□##□ú□üæ
s### ###
#####T#ä###K#########d#########¡###Normal EKG does not R/O AMISingle CK-MB does not R/O AMINitrates, B-blockers lower mortalityASA, Mg+2 lower mortality & CHEAP Give Eminase early if indicated: